Physical Therapy Evaluation

Patient Information:
Name:
Date of Birth:
Gender:
Address:
Phone:
Email:
Emergency Contact:
Name:
Phone:
Medical History:
Primary Care Physician:
Name:
Phone:
Referring Physician (if applicable):
Name:
Phone:
Medical Conditions:
Surgeries/Procedures:
Medications:

Allergies:
Presenting Problem:
Chief Complaint:
Onset:
Location:
Duration:
Aggravating/Alleviating Factors:
Previous Treatment:
Functional Assessment:
Activities of Daily Living (ADLs):
Work/Recreational Activities:

Physical Examination:
Range of Motion (ROM):
Strength:
Posture:
Gait Analysis:
Assessment:
Diagnosis/Impressions:
Plan of Care:
Goals:
Interventions:
Frequency/Duration:

Home Exercise Program (HEP):
Follow-up: